EXHIBIT 1

California Prison Health Care Services (CPHCS)

REQUEST FOR OFFER

For:

Quality Measurement Technical Assistance

Date: June 11, 2008

You are invited to review and respond to this Request for Offer (RFO). To submit an offer for these goods and/or services, you must comply with the instructions contained in this document as well as the requirements stated in the State's Scope of Work (SOW), Attachment A and B. By submitting an offer, your firm agrees to the terms and conditions stated in this RFO and your proposed contract. The State reserves the option to extend the contract for one (1) additional year term at the same rate of the award proposal.

Read the attached document carefully. The RFO due date is: Monday, June 23, 2008. Responses to this RFO and any required copies must be submitted by electronic mail, clearly labeled to the department contact noted below.

Department Contact:

Janet Lewis
Medical Services
California Prison Health Care Services
(916) 324-0596
Janet.lewis@cdcr.ca.gov

Request for Offer

General Information

1. Background and Purpose of the Request for Offer

Project: Quality Measurement Technical Assistance

As a result of the State of California's longstanding failure to provide medical care to prison inmates at constitutionally acceptable levels, the United States District Court for the Northern District of California placed California's prison medical system in receivership. The Receiver's vision statement, as delineated in the Strategic Plan of Action, reads as follows:

> *As soon as practicable, provide constitutionally adequate medical care to patient-inmates of the California Department of Corrections and Rehabilitation (CDCR) within a delivery system the State can successfully manage and sustain.*

The Receiver goes on to describe the two-fold nature of this responsibility as follows:

> A receivership is an extraordinary judicial remedy employed by a federal court only as a last resort when all other attempts to secure compliance with court orders have proven futile. Because it is such an extraordinary remedy, and because federal courts are instructed to employ only as much equitable power as is necessary to cure a constitutional violation, it is incumbent upon the Receiver in this case to move with all possible speed to establish a constitutionally adequate prison medical care system. This is the Receiver's primary order of business.
>
> For the Court's orders to be efficacious, the medical care system established by the Receiver must be sustainable long after federal court supervision has ceased. It is not enough to simply bring CDCR's health care system up to constitutional minimums. The system created must be one that the State itself will be able to maintain long into the future.... Therefore, sustainability of the system under State management and control must be considered by the Receiver as we formulate our plans for building the foundation.

Quality measurement is one of the keys to sustainability. The Strategic Plan of Action includes commitments to quality measurement and improvement as foundational for achieving the Receiver's vision. Performance and outcome measurements must serve to guide quality improvement efforts as well as provide transparency and accountability for internal and external stakeholders.

In collaboration with the Receiver and others, the Office of the Inspector General (OIG) has begun to establish an audit process of clinical performance in CDCR facilities.

Unfortunately, this effort is beginning in a system that has been chronically bereft of useful, accurate, and timely data. There are no modern, enterprise-level data systems in place in CDCR. There are no systematic processes and no staff dedicated to quality data collection. There has been no analysis of necessary sample sizes or sample selection procedures for quality measurement. Throughout the entire nation, there has been limited experience with the use of free-world quality measures in prisons, and there has been no validation of prison-specific measures of access to care.

The goal of this technical assistance project is to advise the Receiver on selection and implementation of performance and outcome measures and strategies that will guide quality improvement efforts as well as provide transparency and accountability for internal and external stakeholders.

As stated in the Receiver's Strategic Plan of Action regarding sustainable quality measurement, evaluation and patient safety programs, "The ultimate goal, which may not be achieved for three years, is to develop balanced scorecards showing each institution's disease burden, utilization, staffing, access-to-care measures, clinical quality indicators and financial performance."

2. Key Dates

It must be understood that time is always of the essence, both for the RFO submittal and contract completion. Offerors are advised of the key dates and times shown below and are expected to adhere to them.

Event		Date
1. Release of RFO		June 11, 2008
2. RFO Response Submission Due date (and time)	COB	June 23, 2008
3. Anticipated Contract Award		June 25, 2008

3. RFO Response Requirements

This RFO and the offeror's response to this document will be made part of the ordering department's Purchase Order and procurement contract file.

Responses must contain all requested information and data and conform to the format described in this section. It is the offeror's responsibility to provide all necessary information for the State to evaluate the response, verify requested information and determine the offeror's ability to perform the tasks and activities defined in the State's Scope of Work, Attachment A and Cost Worksheet, Attachment B provided as required below.

The offeror must **submit electronically** to the department contact name and address contained on the cover sheet to this RFO.

Request for Offer

The majority of the information required to respond to this RFO is contained in the State's Scope of Work, Attachment A and Cost Worksheet, Attachment B.

1. The offeror's "Statement of Work" responds to the State's Scope of Work and will be used to evaluate responsiveness to requirements. This Statement of Work response must map each task/deliverable item back to the Attachments. The response must include any additional information that the offeror deems necessary to explain how the Contractor intends to meet the State's requirements.

    a) Response to the Cost Worksheet, Attachment B. As best value, this Attachment will detail the staff hours by classification, hourly rate per classification, by task(s) and deliverable(s), see format in Attachment B. These costs must map by each classification to the offeror's Statement of Work.

Review of Offers for Award

Responses to this RFO will first be reviewed for responsiveness to the requirements of Exhibit A and B. If a response is missing information required in either Attachment it may be deemed not responsive. Further review is subject to department's discretion.

Award of a contract resulting from this RFO against a CMAS contract will be based on a "best value" method that includes cost as a factor.

For example:

Administrative Criteria	*20%*	*60 points*
Technical Criteria	*40%*	*120 points*
Cost	*40%*	*120 points*
Total	*100%*	*300 points*

An example of Administrative Criteria is:

- *The Organization Chart identifies all proposed project team members and tracks each person to the pertinent task – 25 points maximum*
- *Resumes are included for each proposed project team member and they describe the experience levels in detail, support the Statement of Work, more experience and more points – 35 points maximum*

An example of Technical Criteria is:

- *Outlines and examples of deliverables from other projects are acceptable and support the Statement of Work – 20*
- *Proposed Tasks and Deliverables accomplish the project goals – 40*
- *Work Plan supports the Tasks and Deliverables proposed in the Statement of Work – 30*

Request for Offer

The "best value" calculation as an example such as:

	Offer 1	*Offer 2*	*Offer 3*
Admin Score	*30 pts*	*40 pts*	*54 pts*
Tech Score	*62 pts*	*65 pts*	*66 pts*
Total Points	*92*	*105*	*120*
Cost	*$330,000*	*$285,000*	*$420,000*
	$285,000	*$285,000*	*$285,000*
Cost points	*.86 x 150 = 129.5*	*100 x 150 = 150*	*.68 x 150 = 101.7*
Grand Total	*92 + 129.5 =* ***221.5***	*105 + 150 =* ***255***	*120 + 101.7 =* ***221.7***

In this example, the award goes to Offer 2 as the response that scored the highest points from amongst the Administrative and Technical Criteria as shown in the RFO, combined with the calculated Cost points.

Request for Offer

ATTACHMENT A – SCOPE OF WORK

Statement of Work

Purpose

As a result of the State of California's longstanding failure to provide medical care to prison inmates at constitutionally acceptable levels, the United States District Court for the Northern District of California placed California's prison medical system in receivership. The Receiver's vision statement, as delineated in the Strategic Plan of Action, reads as follows:

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Free-World Quality Measures

The science of clinical measurement has progressed dramatically over the past decade toward consensus on a number of basic principles. The Institute of Medicine's 2006 volume, *Performance Measurement: Accelerating Improvement*,[1] lists the definition requirements as follows:

> Measures of clinical quality are specific quantitative indicators to identify whether the care provided conforms to established treatment goals and care processes for specific clinical presentations. Clinical quality measures generally consist of a descriptive statement or indicator…, a list of data elements that are necessary to construct and/or report the measure, detailed specifications that direct how the data elements are to be collected (including the source of data), the population on whom the measure is constructed, the timing of data collection and reporting, the analytic models used to construct the measure, and the format in which the results will be presented.

According to the National Quality Forum,[2] to be worthy of use in accountability and public reporting, a measure should address one or more key leverage points for improving quality. It should be valid, precise, and reliable, yielding consistent and credible results when implemented. The benefit should outweigh the burden of measurement. The results should be useful in making decisions.

There is now a panoply of free-world measures that meet these criteria, including well-known ambulatory care measures for diabetes, asthma, coronary artery disease, and

[1] Institute of Medicine. *Performance Measurement: Accelerating Improvement*. Washington, DC: National Academy Press; 2006.
[2] National Quality Forum. www.qualityforum.org.

prevention. These measures are used in an approach now known as focused explicit review systems, e.g., the Health Plan Employer Data and Information Set (HEDIS). A second, more global explicit approach for quality assessment is exemplified by RAND's QA Tools system, which uses a broader set of quality measures for a larger number of conditions and yields results that are reported as summary scores. Finally, there is a third approach involving implicit expert (physician) judgments of individual cases (structured physician implicit review).

A recent study[3] used all three measurement approaches to compare the quality of care across Veterans Health Affairs facilities and found moderate to high agreement in quality scores using all three approaches. All three approaches, that is, seemed to be reflecting a similar core notion of what constitutes quality of care. Such agreement bodes well for comparing the quality of care across prisons.

Several state prison systems have made significant progress in introducing free-world measures into corrections. In 1999 the Missouri Department of Corrections began a measurement collaboration with the University of Missouri–Columbia School of Medicine, an experience they described in 2006.[4] In 2002 the University of Texas Medical Branch (UTMB) contracted with the Texas Medical Foundation, a quality improvement organization, to review the quality of care provided by UTMB to state prison inmates. The Texas Medical Foundation performed manual chart audits on 385 inmates and derived measures of utilization and measures of compliance with prevention and chronic care guidelines similar to those above.[5] In addition, the Texas Medical Foundation assessed UTMB for compliance with managed care organization guidelines and correctional standards. The burden of such manual measurement limits the possible frequency and timeliness of this approach and therefore its utility for guiding quality initiatives. UTMB, Missouri, and several other systems more routinely glean a smaller number of quality measures from electronic health records.

Prison Access-to-Care Measures

In addition to free-world quality measures and strategies, the Receiver needs prison-specific measures of access to care. Unlike free-world quality measures and strategies, these have not been standardized or validated.

Currently CDCR access-to-care standards include face-to-face nursing triage for prisoner/patients with symptoms within 24 hours; an appointment with a primary care provider within 5 days for patients classified as urgent or within 14 days for prisoner/patients classified as routine; and high-priority outpatient specialty services within 14 calendar days or routine services within 90 calendar days. Most states have

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[3] Kerr EA, et al. Quality by any other name? A comparison of three profiling systems for assessing health care quality. *Health Services Research*, 42 (5): 2070-2087.

[4] Stone TT, et al. Health care quality in prisons: A comprehensive matrix for evaluation. *Journal of Correctional Health Care*, 12 (2): 89-103.

[5] Texas Medical Foundation. An evaluation of correctional health care services provided by University of Texas Medical Branch Correctional Managed Care. January 2005.

variations on such themes, often distinguishing weekdays from weekends for non-urgent complaints. California's standard for urgent primary care visits within 5 days lies well beyond what many other state correctional systems require. The standards for TriCare, the system serving military beneficiaries, include urgent primary care within 24 hours, routine primary care within 7 days, and routine specialty care within 30 days.

Some states have built their standards into enterprise-level information systems that generate reports on access-to-care compliance. Over the next two years, the Receiver will deploy an electronic scheduling and tracking system capable of generating such reports. Meanwhile, the Receiver has launched a major Access-to-Care Initiative that will redesign the core processes of primary care, specialty care, and infirmary/hospital care. This initiative will entail development of new care coordination and utilization management programs and deployment of custody access teams dedicated to escorting inmate-patients to health care encounters, all supported by new health information technology.

Health Information Technology

Over the next two years, the Receiver will complete installation of an enterprise-wide pharmacy system, will deploy the scheduling and tracking system just mentioned, will create a clinical data repository, and will begin development of a clinical data warehouse for population management. It would be prudent to develop credible approaches to quality measurement before "hardwiring" data elements and reports into the electronic system, thus the urgency of this quality measurement technical assistance project.

While data collection will be easier once health information technology is in place, the fact remains that the Receiver must begin measuring the quality of care now, both to guide quality improvement efforts as well as to provide transparency and accountability. The immediate challenge is to develop credible and efficient strategies using both free-world quality measures and prison-specific access-to-care measures in a data-poor environment depending largely on paper charts that are still too often in shambles. Ideally the measurement approaches can reflect the quality of a given clinical process or outcome in a paper environment, through a mixed paper/electronic environment, and into a completely electronic environment.

Request for Offer

A. Scope:

At a minimum, the contractor team is to address the following outcomes and outputs with work plans including strategies, time lines, and accountabilities (responsible parties). It is desirable to have the following deliverables presented incrementally:

1. Assess the adequacy of current clinical quality measurement approaches in CDCR, including:
   - The audit instrument and strategies used by the Quality Management Assistance Teams (QMAT) in 2004-2005 and used sporadically since.
   - The audit instrument and strategies used by the Office of the Inspector General (OIG) in its 2008 prison medical care inspections.
   - The strategies used to survey the California Out-of-State Correctional Facilities (COCFs).
   - The quality improvement measurement strategies used in the Access-to-Care Initiative.

2. Survey the clinical quality measurement approaches being used by leading state prison systems, the Federal Bureau of Prisons, and other relevant systems, with particular focus on standards and measures of access to care.

3. Given the current and expected quality infrastructure within the prison medical care system and the expected incremental transition from a paper to an electronic environment, recommend a set of reasonable two-year approaches to quality measurement, including data definitions and collection strategies, for purposes of both quality improvement and accountability.

B. CPHCS ROLES AND RESPONSIBILITIES

1. The CPHCS shall be responsible for reviewing the deliverables as submitted in a timely manner.

C. CONSULTANT ROLES AND RESPONSIBILITIES

1. The consultant shall be responsible for completing deliverables in the agreed upon timeframe.

2. The consultant must actively participate in coordinating, meeting with, and gathering the required information. The consultant will actively participate in information gathering meetings, fact-finding meetings, working sessions, status reporting, both verbal and written, presentations, and general communication on an ongoing basis to help ensure the success of the project.

3. The consultant may produce the following documentation as needed, however, these are not considered a separate deliverable:
   - Information Gathering Meetings Documentation
   - Fact-Finding Meetings
   - Working Sessions
   - Presentations
   - General Communications Notes and Documents

4. The consultant will work with the Chief Information Officer, California Prison Health Care Services (CPHCS) and the Chief Executive Officer – Medical Services, California Prison Health Care Receivership to ensure any issues concerning the work are reported.

D. ASSUMPTIONS AND CONSTRAINTS

1. Travel will be required.

2. Travel and miscellaneous expenses are anticipated, should they occur, they must be approved in advance by the CPHCS contract manager. Approved travel costs may not exceed the current Department of Personnel Administration (DPA) travel and per diem rates.

E. STAFFING REQUIREMENTS

1. The consultant team is required to possess the experience and expertise required for completion of the quality management deliverables. Contractors must include the names, classifications, certifications (if applicable) and resumes of personnel, including sub contractors, who will be assigned to the project.

F. CPHCS CONTRACT MANAGER

The manager for the work contained in this contract will be:

Janet Lewis
Staff Services Manager II
California Prison Health Care Receivership Corporation
P.O. Box 4038
Sacramento, CA 95812-4038

Request for Offer

G. PAYMENT AND INVOICING

1. The consultant will invoice monthly.

2. The consultant will provide a status report with invoice.

3. Invoices will identify the contract number, the time period, and the deliverable number and deliverable title.

4. Invoices will be submitted to the contract manager, as stated in Section F.

Request for Offer

ATTACHMENT B-1 – COST WORKSHEET

Job Title or Classification	Hours	Rate Per Hour	Extended Total	Task # or Name

Subtotal $_____

Other Costs, Travel, (if allowed) etc. +_____

Total Costs **$**_____

	2008-0869 TASK 1			TASK 2			TASK 3			
	Rates	**Hours**	**Requested**	**Rates**	**Hours**	**Requested**	**Rates**	**Hours**	**Requested**	**Summary**
Sr Natural Scientist	$244.00	120	$29,280	$244.00	56	$13,664	$244.00	80	19,520	$62,464
Sr Policy Researcher	$256.13	40	$10,245	$256.13	240	$61,470	$256.13	80	20,490	$92,205
Project Associate I	$139.50	160	$22,320	$139.50	80	$11,160	$139.50	240	33,480	$66,960
Project Associate II	$136.25	80	$10,900	$136.25	400	$54,500	$136.25	160	21,800	$87,200
Policy Researcher	$188.88	80	$15,110	$188.88	80	$15,110	$188.88	240	45,330	$75,550
Sr Natural Scientist II	$244.00	8	$1,952	$244.00	8	$1,952	$244.00	8	1,952	$5,856
Admin Assistant	$98.25	120	$11,790	$98.25	120	$11,790	$98.25	120	11,790	$35,370
Totals		608	**$101,597**		984	**$169,646**		928	**154,362**	**$425,605**

Rates include all costs including travel.